SETTING PRIORITIES STRAIGHT

Manitoba's Position on Federal Reductions in Funding Health and Higher Education

June 1986

Manitoba

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ON

FEDERAL REDUCTIONS IN FUNDING

HEALTH AND HIGHER EDUCATION

JUNE, 1986

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TABLE OF CONTENTS

	Page
Introduction	1
The Need for Services	2
° Higher Education Services	2
° Health Services	4
° Current Funding Levels of Services	6
Future Funding Requirements	8
Canada in the Context of OECD Nations	9
The Federal Proposal — Bill C-96	11
Provincial and Organizational Reactions	13
The Way Forward	15
Conclusion	16

Appendices

A: Excerpts from the Study Team Report on Health and Sports

B: Excerpts from Medicare: The Public Good and the Private Practice, National Council of Welfare, Ottawa (1982)

C: Financing Health and Higher Education in Canada: Manitoba Examines the Issues (1986)

D: Social Expenditure in OECD Countries, 1960-1981 (Table)

SETTING PRIORITIES STRAIGHT

Proposed Federal Reductions to Health and Higher Education -- Manitoba's Position on Bill C-96

Introduction

It is not common for provinces to appear before Committees considering federal legislation. Nevertheless, when issues of fundamental importance are being legislated without needs assessment or general agreement from provinces, it is appropriate for provinces to make their views known. Therefore, the Government of Manitoba welcomes this opportunity to address the matter of the funding of health and higher education services in Canada and, in so doing, to stand up for the needs of our citizens. Bill C-96, an Act to Amend the Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act, 1977, goes to the very heart of our Canadian social heritage and signals a fundamental departure from historic patterns of federal funding of health and higher education. It is being forced through Parliament with indecent haste, including the use of procedural motions to limit debate. No national hearings are taking place desite the precedents of other parliamentary committees hearing issues of similar magnitude.

The Government of Manitoba believes that passage of this Bill would lead Canada in the wrong directions. Bill C-96:

- suggests that Canadians should devote a declining share of our economy to health and higher education services at a time when all forecasts show that needs are clearly increasing and evidence suggests that our country can afford to maintain and improve our services;

- represents a significant and unilateral withdrawal of federal responsibility at a time when the federal presence is still needed and its role has been reaffirmed as recently as 1984, with all-party support for passage of the Canada Health Act; and

- passes federal burdens onto provinces at a time when provincial fiscal circumstances are particularly strained and federal fiscal circumstances are expected to show marked improvement.

One particular quote effectively summarizes what many Canadians believe will be the impact of this measure. In the words of the Canadian Medical Association, the federal government, by this measure, has "abandoned the dream of Canadians of having access to reasonably equal services, no matter where they live or work".[1]

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[1] Canadian Medical Association, February 14, 1986.

By this Act, the federal government not only unilaterally withdraws from a fiscal role, but imposes real dangers to the affordability, accessibility, quality and availability of services vital to all Canadians' well-being.

Bill C-96 is ill-advised. Along with increasing numbers of men and women throughout this country, Manitoba believes that passage of this Bill must be delayed to permit its full impact to be assessed and understood.

The Need for Services

Higher Education Services

It is a widely acknowledged fact that the availability of widespread, varied and high quality post-secondary education is fundamental to both economic and social development. Underlining this critical role of education, Walter F. Light, Chair and Chief Executive Officer of Northern Telecom said, "It is not only the quality and quantity of our engineers that is crucial to our future services. It is also the quantity and quality of our writers, our philosophers, our social scientists, our political scientists, our psychologists, our historians....All disciplines are important to our future."[2]

Yet, according to the Council of Ministers of Education of Canada, as a nation we have slightly decreased our overall spending on higher education from 2.14% in 1977/78 to 2.08% of Gross Domestic Product (GDP) in 1984/85. Manitoba on the other hand began at a higher base and has slightly increased its spending from 2.28% to 2.29% GDP in the period 1977/78 to 1984/85, ranking third in Canada by the end of this time.[3]

Canadians recognize their needs for training, higher education and research. Record numbers of full- and part-time graduate and undergraduate students are enrolled in our system, as the next table shows.

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2 Walter F. Light, Address to the Annual Meeting of Northern Telecom, 1984.

3 Interprovincial spending comparisons, March, 1986.

TABLE 1

ENROLMENT: UNIVERSITIES AND COLLEGES; CANADA, 1982/83 TO 1984/85

	University		Community College	
	Full-Time	Part-Time	Full-Time	Total
1982/83	425,389	266,380	295,586	988,355
1983/84	450,531	278,700	313,364	1,042,595
1984/85	460,810	276,390	317,020	1,054,220

Source: Statistics Canada, Education in Canada, cat. 81-229 for 1982/83 and 1983/84 and Advance Statistics of Education, cat. 81-220 for 1984/85.

Full-time students comprise 38% of the primary target group of 18-21 year olds. Overall rates of increase in enrolment have moderated in recent years, but have averaged 4-5% per year between 1981 and 1985. In addition to traditional campus-centered operations, both colleges and universities have developed outreach programs to meet rural, northern and native people's needs more effectively. In total, university enrolment increased 27% while that of colleges grew 36% in the years 1977/78 to 1984/85.[4]

The resulting cost pressures have forced universities to limit enrolments in some faculties and to increase class sizes in most areas. Manitoba believes that little, if any, room remains to achieve further such economies of scale or adjustments to class size without sacrificing educational quality and accessibility.

Therefore, of the many fundamental education policy questions facing us, two of the most immediate are:

- **First, is there sufficient equity of access for qualified Canadians to pursue higher education?**

- **Second, can our system attract, train and retrain highly competent staff, both for teaching and research?**

Manitoba believes that at present we have no further room to maneuver on these basic questions. Further cuts will impair both quality and access. The findings of the Canadian Federation of Students, the Association of Universities and Colleges of Canada, the Canadian Council of Ministers of Education and the Canadian Association of University Teachers also provide relevant insights on these matters.

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[4] Statistics Canada, Advanced Statistics of Education, catalogue 81-220.

Even the Nielsen Task Force concluded, "We have found no objective measures which demonstrate that the system is over-funded. No recent report suggests that there is a case to be made for reduced funding for post-secondary education."[5] Moreover, severe cost pressures are present. Capital plant is deteriorating. New technology, necessary for instruction and research, is more costly both to aquire and to maintain than equipment it replaced. More students are seeking support from Student Aid programs, underlining our growing concern about accessibility, and indicating the limited capacity of student fees to raise significant new revenues. Fees now provide about 12% of university costs, and fee structures should be expected to grow only in relation to the total economy if access to higher education for all is to be protected.

In summary, higher education services are facing serious cost pressure. Further reductions in support would put these services at risk and severely damage both the economic and human capital development function which is the major role of higher education.

Health Services

Health care needs have been extensively studied by various groups including the Canadian Medical Association (CMA), the Conference Board and provincial health departments. All available studies have lead to remarkably similar conclusions which were accurately summarized in the recent Nielsen Report on Health and Sport.[9] Key issues cited include:

- the ageing trend, which, according to both the CMA and the Conference Board, will add at least 1% per year real growth in costs, quite apart from other factors;
- health technology, which, in spite of attempts at controls on unproven or inappropriate use, adds substantial costs to both capital and operating budgets; kidney dialysis costs $15,000-18,000 per patient per year; by-pass surgery $20,000-25,000 per operation, and so forth;
- increases in physician supply in excess of population growth, coupled with continued mal-distribution of physician services -- some urban areas have too many doctors while rural and northern areas have too few;

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[5] Service to the Public, Education and Research Task Force on Program Review, Ottawa, November, 1985, page 15.

[9] Page 19, ff. Health and Sports Study Team Report to the Task Force on Program Review, Ottawa, 1986.

- evidence that environmental, workplace and lifestyle factors are the dominant causal factors in much disease; acute care can only treat some of these diseases, usually at great cost; prevention is the best long-term solution, which means national leadership in environmental reform and health education.

In addition, reports from other jurisdictions including Manitoba, add further issues:

- poverty and illness are closely related -- it is striking that poverty is highly correlated with increased rates of the costliest diseases to treat, most of which are currently incurable;[10]

- native people experience 2.5 times the incidence of illness and consume 1.25 times the per capita days care of non-native people;[11]

- only 7% of all aged people are institutionalized;[12]

- disability levels are increasing sharply, with attendent long-term and often high-cost care.

Attention must be paid to strategic initiatives directed at such high risk populations. Natural justice, social responsibility, public opinion and current legislation all require that acutely ill and vulnerable people are served. In Manitoba's view, maintaining our capacity to care for these people must be the overriding consideration.

Long-term cost containment will only be possible through:

(a) public education leading to changes in destructive health habits;

(b) environmental reform and workplace safety;

(c) investment in greater differentiation of staff and resources so that care is given in the most economical as well as humane manner possible;

(d) strategic approaches to high risk populations coupled with less reliance on costly institutional care;

(e) limitations on the numbers of the highest cost staff resources made available;

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[10] Page 67, Medicare -- The Private Good and the Public Practice, National Council of Welfare, May, 1982. Table in Appendix 2.

[11] Report of the Health Services Review Committee, Volume III, Winnipeg, Queen's Printer, November, 1985, Page 37.

[12] Ibid, Page 28.

(f) incentives to increase quality, not amount of services; currently, the only major way physicians can increase their income is to increase volume of service.

In order to achieve these changes, investment in new approaches is a key strategy.[13] Costs in the current system will not shift until the new approaches are in place, because existing, real needs must be met.

Current Funding Levels of Health and Higher Education Services

Manitoba believes that a developed nation must ensure basic public services for its people -- including progressive education and full health care. Low educational attainment contributes to poverty and economic decline; illness is its own burden -- financial ruin must not be its companion.

The fundamental policy issues of adequate service availability, accessibility and affordability have sometimes been obscurred by the debate about respective federal and provincial funding levels in health and higher education. Thankfully, the health side of that non-productive debate has been laid to rest with the publication of data showing federal and provincial shares of health costs by the Nielsen Task Force. This federal data confirm that, as the provinces have stated, the federal government currently funds only about 40% of provincial health expenditures.[14]

Furthermore, evidence from the following chart shows that the federal deficit is not primarily related to sharply rising payments for health and higher education. In fact, such payments have been an extremely stable factor in federal expenditures at somewhat less than 5% of GNP in the period 1977 to 1984.

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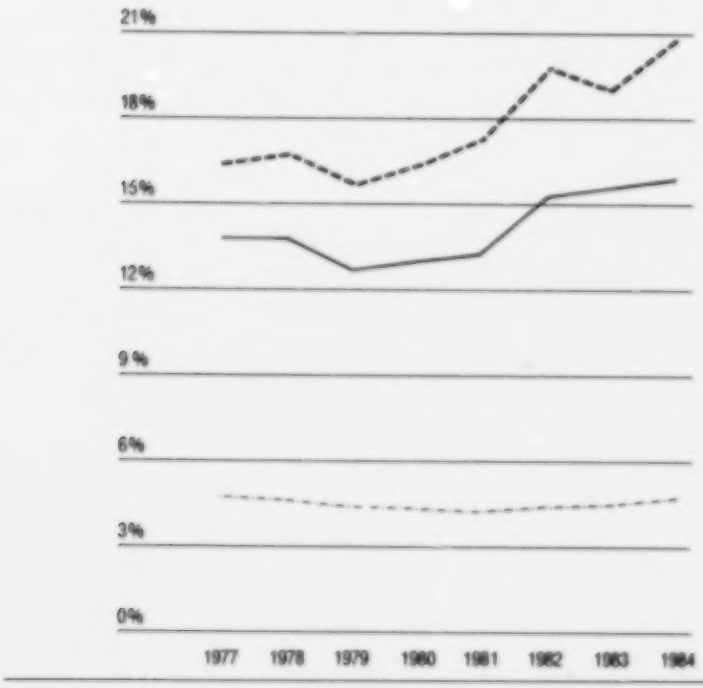
[13] For a particularly helpful treatment of the issue of future health planning strategies, see Issues in Preventive Health Care, Science Council of Canada, 1985.

[14] See Appendix C.

FEDERAL TRANSFER TO THE PROVINCES AND OTHER FEDERAL EXPENDITURES AS PROPORTIONS OF THE GNP, 1977 to 1984



Source National Income and Expenditure Accounts

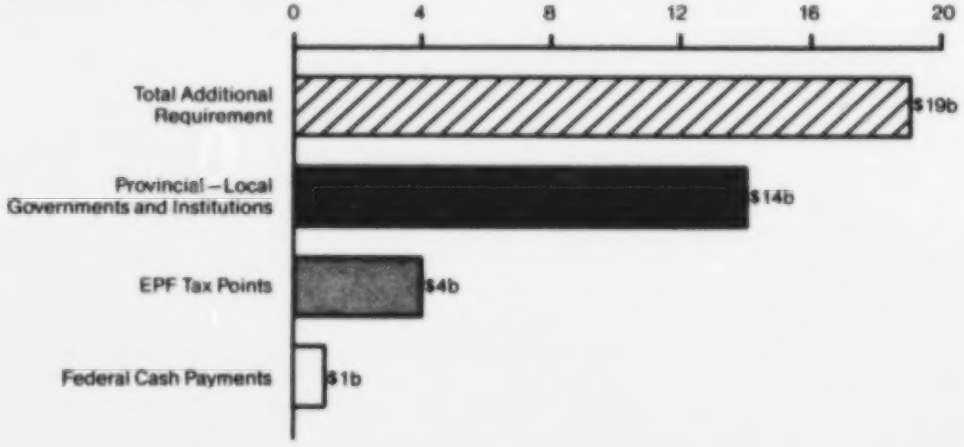
Utilizing consistent definitions and placing the federal role in the most comprehensive light, it has been shown conclusively that in 1979/80 the federal government paid about 50% of all health and higher education costs; it now pays about 43%. If passed, Bill C-96 means a further sharp decline in the federal share of funding for health and higher education. By 1990/91, the federal share will depend on the depth of the federal cuts and levels of expenditure needed to meet the health care and higher education requirements of Canadians.

Future Funding Requirements

For the period 1985/86 to 1990/91, the following chart depicts the projected growth in service requirements, contrasted with the projected levels of support from each source.

Increased Health and Higher Education Requirements, 1985/86 to 1990/91

Sources of Funding



Source: Federal Department of Finance
Manitoba Department of Finance

During the period 1977/78 to 1985/86, cost increases for health and higher education combined have averaged 3.5% per year above economic growth. However, the underlying trend was somewhat lower as some of the apparent growth resulted from the economic decline in 1982/83. The Conference Board of America and recent Canadian studies indicate underlying growth of 2% above economic growth for the next decade. In large part, this is because by 1991, the number of people over 65 in Canada will be one-third higher than in 1977/78. These people must be served.

Therefore, it would be a grave error to think that our health care system can be driven into more efficient practices by fiscal stringency alone. Indeed, the opposite is true -- and for very good reasons. The

sick cannot be laid-off, nor should they be. The availability of ambulances and emergency acute care cannot and should not be cut back. Cancers cannot and should not go untreated; kidney dialysis machines cannot and should not be mothballed. Thus, undue fiscal stringency is more likely to delay development of new services, and new strategies most needed to pull the system into less costly and more effective patterns of service.

In summary, there is every reason to expect both health and higher education requirements to expand at a rate somewhat above economic growth for the next decade. Decisions to reduce funding below these requirements will have very negative effects, including the disabling of the very strategies most likely to achieve long-term cost containment.

Let us now turn to a review of Canada's expenditure in relation to those of other developed nations.

Canada in the Context of OECD Nations

There is a persistent myth, often mistakenly supported by Canadian and American commentators, that Canada's overall social spending is very high. Many believe that even if it is not too high, it is nevertheless much higher than that of the United States. There is no evidence to support such assertions.

The Organization for Economic Cooperation and Development in a 1983 paper entitled The Growth of Social Expenditure[6] cited the following data:

- Canada ranked 10th out of 18 reporting countries on per capita spending in US dollars in 1981 on all social expenditure, at $1,028. The United States was 7th, at $1,196, or 16% higher.

- Canada is 12th out of 18 in percentage of Gross Domestic Product allocated to social expenditure at 21.7%. The USA is 13th at a virtually identical 21.0%.

Given recent health cost increases in the United States, it is likely that the USA exceeds Canada in this indicator as well.

Canada's publicly based, universal system has resulted in quality health services at reasonable costs. In 1982, Canada ranked seventh among the 12 OECD members in proportion of our economy allocated to public health expenditure.[7] The average was 6.1%; Canada spent 5.9%.

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[6] The Growth of Social Expenditure: Overview and Main Issues: OECD, Paris, August 1983. See also Appendix D.

[7] Page 14, Health Spending, Its Growth and Control, OECD, December, 1985.

Such comparisons examine only the public sector services; when all expenditures on health, both public and private are examined, Canada still ranks close to the average. We are fifth out of 12 nations, well below the leaders. What is more to the point is that the American system, which is approximately half public and half private, has much higher total costs (10.9% vs. 8.4% of Gross National Product) than Canada. More fundamentally still, there are 35 million Americans without any right to insured care whatsoever, most of whom are poor.[8]

A number of conclusions arise from the examination of the OECD information, U.S. experience and other studies:

- we have an efficient, economical system;
- ours is a fair system, covering all Canadians;
- our cost experience is well within international norms;
- other nations, reflecting their priorities, spend a higher proportion of their total income on health;
- no developed nation has reduced the proportion of its economy allocated to health care; on the contrary, all have devoted a slowly increasing proportion to such services; and
- the only developed nation without a national health insurance program has by far the highest costs, as well as the poorest coverage.

Data for education is not separated into public and post-secondary areas. Overall data however, again places Canada in the middle grouping of nations.

In summary, Canada actually allocates less per capita to social expenditure than most OECD nations; Canada and the USA are virtually tied in their respective allocations. Canada is certainly not an overspender, nor does it even rank as a particularly big spender. Adopting Bill C-96 would cause Canada to fall further in the ranks of developed nations in terms of the priority and resources devoted to these services. It is in this context that Bill C-96, which seeks to actually shrink the proportion of total income allocated to health and higher education services, should be examined.

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[8] Dr. Robert H. Brook, Rand Corporation, Speech to Financial Post Conference on Health, Ottawa, April 29, 1986.

Denise Brady, The Cruel Cost of Cutting Medical Expenses, Discover, May 1986.

The Federal Proposal — Bill C-96

The current federal mechanism for funding health and higher education is examined in detail in Appendix C. In simplified terms, the present formula:

(a) calculates an equal national per capita grant based upon a three-year average of GNP growth or decline;

(b) calculates the yield in each province of 13.5 personal and 1.0 corporate tax points which were transferred in 1977/78 as part of the EPF package (these points are subject to equalization);

(c) determines the federal cash grant by subtracting (b) from (a) and pays that grant in cash to each province.

Bill C-96, in essence, amends the formula to 2% less than growth in GNP subject, in extreme conditions, to floor provisions related to a resumption of rapid inflation.

Much has been made by the federal government of the fact that this change yields support which will slightly exceed inflation under current economic forecasts when the tax points transferred in 1977/78 are included. However, as previous sections of this Brief point out and, as the Nielsen Task Force confirms, the costs of providing health care and higher education to Canadians will exceed both inflation and economic growth. Because of this fact, by 1990/91, the federal share will decline to about 36% of overall costs, from its current 43%.

Even more to the point is the direct impact of this formula upon federal expenditures. The Table below contrasts the growth of cash payments in the 1977/78 to 1984/85 period of $4.2 billion with the federal projections of growth in the 1985/86 to 1990/91 period of only $955 million.

FEDERAL CASH PAYMENTS IN SUPPORT OF HEALTH AND HIGHER EDUCATION
($ Millions)

Period 1: 1977/78 to 1984/85

1977/78	1979/79	1979/80	1980/81	1981/82	1982/83	1983/84	1984/85
3,985	4,485	5,002	5,458	6,095	6,433	7,527	8,209

Period 2: 1985/86 to 1990/91

1985/86	1986/87	1987/88	1988/89	1989/90	1990/91
8,802	9,045	9,219	9,381	9,533	9,757

Source: Federal Department of Finance.

Throughout the recent federal Budget documents, the terms "expenditure reduction" and "program reduction" are repeated. The federal government apparently takes great pride in its mechanical pursuit of deficit reduction, no matter what is gobbled up in the process -- whether it be family allowances for children, education for young adults, or health care for all.

Manitoba is particularly concerned about the stated intention of the federal government to reduce its program expenditure to the proportion of GNP thus allocated in 1960/61. This goal ignores the development of Medicare, the needs of our country for higher education and the realities of rapid demographic changes since 1960/61. We are a vastly wealthier nation than we were in 1960/61 -- wealthier in material terms but equally important, wealthier in our secure access to health care, education and a range of other services vital to our well-being. Few among us would willingly choose to return to pre-1960. Yet, that is the stated intent of the current federal government.

It is instructive to review the priorities of this federal government. Bank bail outs have cost $2.0 billion, and capital gains exemptions will result in revenue losses already estimated at $4.5 billion by 1990/91, well in excess of those resulting from the now infamous Scientific Research Tax Credit program. Rapidly rising tax expenditures via increased RRSP deductions will further impact upon tax revenues -- all in favour of the already wealthy. The total revenue shift from corporate to personal income tax is now estimated to exceed $14 billion by 1990/91, with the severest impacts felt by moderate- and middle-income Canadians.

Against this massive preference for the already wealthy and for the corporate sector stand increases of less than $200 million per year for health and education services to all Canadians.

In the context of federal revenue growth of an estimated $35 billion,[15] the $955 million increase between now and 1990/91 appears grossly inadequate evidence of the federal commitment to a "sacred trust". In the face of annual funding needs for health and higher education of an additional $19 billion by 1990/91, the $955 million federal cash increase leaves a massive $18 billion gap to be financed by provincially generated revenues, including the tax points transferred in 1977/78 for this purpose.

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[15] Page 43, The Fiscal Plan, Federal Department of Finance, February, 1986.

Provincial and Organizational Reactions

Canadians see that these reduced federal cash payments will result in the federal government becoming a 17¢ cash contributor to every dollar of health and higher education costs by 1990/91. Poorer provinces face the alternatives set out in Newfoundland's Green Paper:[16]

- privatization, including premiums, user fees, extra billing;
- expenditure cuts (service reductions);
- deficit financing; and
- tax increases.

As the Green Paper stated, "no options are particularly attractive."

This proposal to shift the cost burden to provinces deeply disadvantages the poorer provinces. Provinces which receive Equalization payments simply do not have the fiscal capacity to sharply increase revenues without distorting their taxation structures.

TABLE 4

FISCAL CAPACITY BY PROVINCE, 1985/86

	(%)
Newfoundland	60
Prince Edward Island	61
Nova Scotia	72
New Brunswick	67
Quebec	79
Ontario	98
Manitoba	81
Saskatchewan	105
Alberta	200
British Columbia	104
National Average	100

Source: Green Paper on Our Health Care System, Government of Newfoundland and Labrador, January, 1986.

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[16] A Green Paper on our Health Care System Expenditures and Funding, Government of Newfoundland and Labrador, January, 1986.

Based upon the above data, planned federal cutbacks would erode seriously the economic well-being of six of our 10 provinces. The alternative is equally unacceptable; a two- or even three-tiered health care system.

Dr. Vail, of the Canadian Medical Association, put this possibility strongly:

> "We will have one quality of health care in the rich provinces and second or third rate services in the poor provinces. The dream of Canadians of having access to reasonably comparable health services, no matter where they live or travel, appears to have been abandoned by the Government of Canada."[17]

However, the last word on the cuts came from the Federal Study Team on Health and Sport -- part of the Nielsen Task Force on Program Review. They stated bluntly:

> "Based on this review, the Study Team concludes that there are no compelling program reasons to reduce transfer payments...The Team fears that this action by the federal government could substantially reduce its role in Canada's health care system."[18]

The whole tenor of the Report is to call upon the federal government to accept a positive leadership role in resolving the funding dilemma. That is and has been the goal of Manitoba's interventions historically, under administrations of all political stripes. For example, the Honourable Brian Ransom, a former Manitoba Minister of Finance, said in 1981 of a similar threat to the Established Programs Financing Act:

> "In our view, too much effort and too much goodwill over too many decades have gone into the creation of these arrangements for them to be risked, or even sacrificed, for some short-term, short-sighted federal budgetary or policital advantage."[19]

Indeed, when Members of the current federal government were in Opposition, they, including the Prime Minister and the Finance Minister, waxed eloquent about their support for increased proportions of federal

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[17] Canadian Medical Association, February 13, 1986.

[18] Page 13, Study Team Report on Health and Sport to the Task Force Program Review, Ottawa, November 1985.

[19] The Honourable Brian Ransom to the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements, May, 1981.

funding to Medicare. In 1982, the current Minister of Finance stated his opposition to another unilateral cut in federal support for health and higher education, during the debate on the removal of the "revenue guarantee."

Mr. Wilson said:

> "The provinces are now moving into a deficit position; a position which will make it more difficult for them to finance this shift in spending. That is not co-operative federalism. That is predatory federalism and it will not and cannot work in this country."[20]

In the 1984 election campaign, the present party in government stated its views on financing health and education forthright'y:

> "We are committed to sustaining the current federal financial commitment according to the formula set out in the 1977 Agreement..."

They acknowledged in Opposition the current provincial/federal 60/40 health funding split, which, until recently, they denied in government. Yet, by Bill C-96 they would reduce the overall federal level in both health and post-secondary education to 36% from today's 43%.

The current federal government unanimously supported the Canada Health Act while in Opposition. Today, their Study Team recommends that the Act be scrapped. Why? Because federal cutbacks make enforcement of the Act's provisions impossible. The Study Team states that the Act "restricts the flexibility of provinces in responding to pressures within their health systems..." These are euphemisms for the fact that the Canada Health Act is the only thing standing between Canadians and user fees, deterrent fees, extra billing and privatization which the Study Team and government apparently favour. That is why the Study Team concludes that the Act must "be amended or replaced."[21]

The Way Forward

First, Manitoba agrees that our current health system needs substantial reform and redirection away from its current focus on illness and acute care and towards a wellness-prevention orientation. Our Province has begun such a process and will continue to pursue it vigorously.

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20 House of Commons Debates, March 23, 1982.

21 Page 14, Study Team Report on Health and Sport to the Task Force on Program Review, Ottawa, November 1985.

Second, Manitoba shares all governments' concerns about high deficits, and their carrying costs which reduce funding available for vital services.

The direction forward for health and higher education lies in:

- sustaining the existing excellent services which Canadians rightly value as among the best in the world;
- engaging in federal-provincial dialogue on future needs and directions;
- evolving incentives to persuade caregivers to practice in less costly and less institutionally focussed ways; and
- undergirding our capacity to give leadership with comprehensive and equitable tax reform.

Medicare and higher education, though they may be narrowly and legalistically viewed as areas of provincial jurisdiction, are, in reality, powerful and fundamental engines of economic progress and social justice. As such, their sustenance and future direction is legitimately both a federal and a provincial concern.

Conclusion

Bill C-96 will deeply and adversely affect provinces' ability to sustain services. Its introduction clearly suggests to provinces that the unilateral actions so deplored in previous administrations can be expected to continue in this one. It also sets the stage for acrimonious debate on many aspects of the "Nielsen Report". But, most of all, it is unnecessary. The federal government has moved to secure $35 billion in new tax revenues by 1990/91. At present, some 11.1% of federal revenue goes to health and higher education. If only 10% of the new funds were so allocated, needs could be met and cooperation in trust would be once again possible. The Government of Manitoba therefore calls upon your Committee to recommend the removal of Bill C-96 and its replacement with federal leadership, planning and fair federal funding for health and higher education.

APPENDIX A

EXCERPTS FROM THE STUDY TEAM REPORT ON HEALTH AND SPORTS, THE TASK FORCE ON PROGRAM REVIEW

Ottawa, 1985

On the issue of proposed cutbacks in funding:

"However, based on this review, the study team concludes that there are no compelling program reasons to reduce transfer payments. Thus, the announced intent of the federal government to reduce the amount of transfer payments by $6 billion over the next five years is seen strictly as a necessary fiscal measure. The team fears, however, that this action by the federal government could substantially reduce its role in Canada's health care system. The percentage of federal government contributions to provincial health programs is currently at approximately 40%. The team found no evidence that would indicate that our health system is significantly "overfunded" or "underfunded" - rather a balance overall appears to have been achieved at the present time. However, cost pressures are building up, as our "Health Issues" paper shows.[1]

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[1] Page 13.

On the share of current total health expenditures provided by federal support.

1985/86 Estimates of EPF (Health) Contributions in Relation to Estimated Provincial Health Expenditure[2]

Prov.	Cash Contrib. ($ Million) (1)	Tax Abatement & Equal. ($ Million) (2)	Total (1) & (2) ($ Million) (3)	Total Provincial Health Exp. ($ Million) (4)	% Percentage (3) of (4) (5)
NFLD	1,475.5	1,474.5	1,475.5	1,475.5	44.9
PEI	37.3	19.1	56.4	120.5	46.8
NS	258.2	132.1	390.1	864.2	45.2
NB	211.0	107.9	318.8	697.4	45.7
QUE	1,475.5	1,441.4	2,916.9	7,354.2	39.7
ONT	2,497.4	1,519.9	4,017.3	9,235.6	43.5
MAN	313.6	160.4	474.0	1,186.6	39.9
SASK	321.0	130.7	451.8	1,103.0	41.0
ALTA	561.7	478.9	1,040.5	3,146.5	33.1
BC	811.3	470.2	1,281.5	3,213.4	39.9
NWT	13.6	8.9	22.6	88.5	25.5
YUKON	5.9	4.1	10.1	28.8	35.1
TOTAL	6,676.7*	4,560.7*	11,237.4*	27,661.4**	40.6

*Source: Department of Finance for EPF data
**Source: Department of Health and Welfare Canada (HWC) for Provincial Health Expenditures

[2] Page 74.

On the effects of federal reductions upon provinces:

"**Funding.** We found that officials in all provinces support EPF but it is clear that all are very concerned about changes that have been made to the original arrangements by the federal government. Cost escalation is a concern for all provinces and there is no evidence that any jurisdiction will be able to hold cost increases at or below the inflation rates in the forseeable future. Provinces feel that the impact of aging, technology, medical manpower and usage rates are and will continue to exert substantial upward pressures on costs. In this situation, an EPF escalator based on GNP is likely to result in federal payments growing at a rate slower than health costs. (emphasis added).

Reductions in federal funding under EPF will, for the provinces, result in one or more of the following:

transfers of health costs to individuals (within the limits of the Canada Health Act);

increased taxes at provincial levels;

reduction in services and/or quality of health care services;

reduction in provincial programs in areas other than health care."[3]

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[3] Page 90.

APPENDIX B

EXCERPTS FROM

medicare:
the public good and private practice

a report by the
national council of welfare
on canada's health insurance system

may 1982

MEDICARE AND THE POOR

All Canadians benefited from the coming of national health insurance, but none more than the poor. Medicare marked a major step forward in closing the health gap that separates low-income households from the rest.

The Health Gap

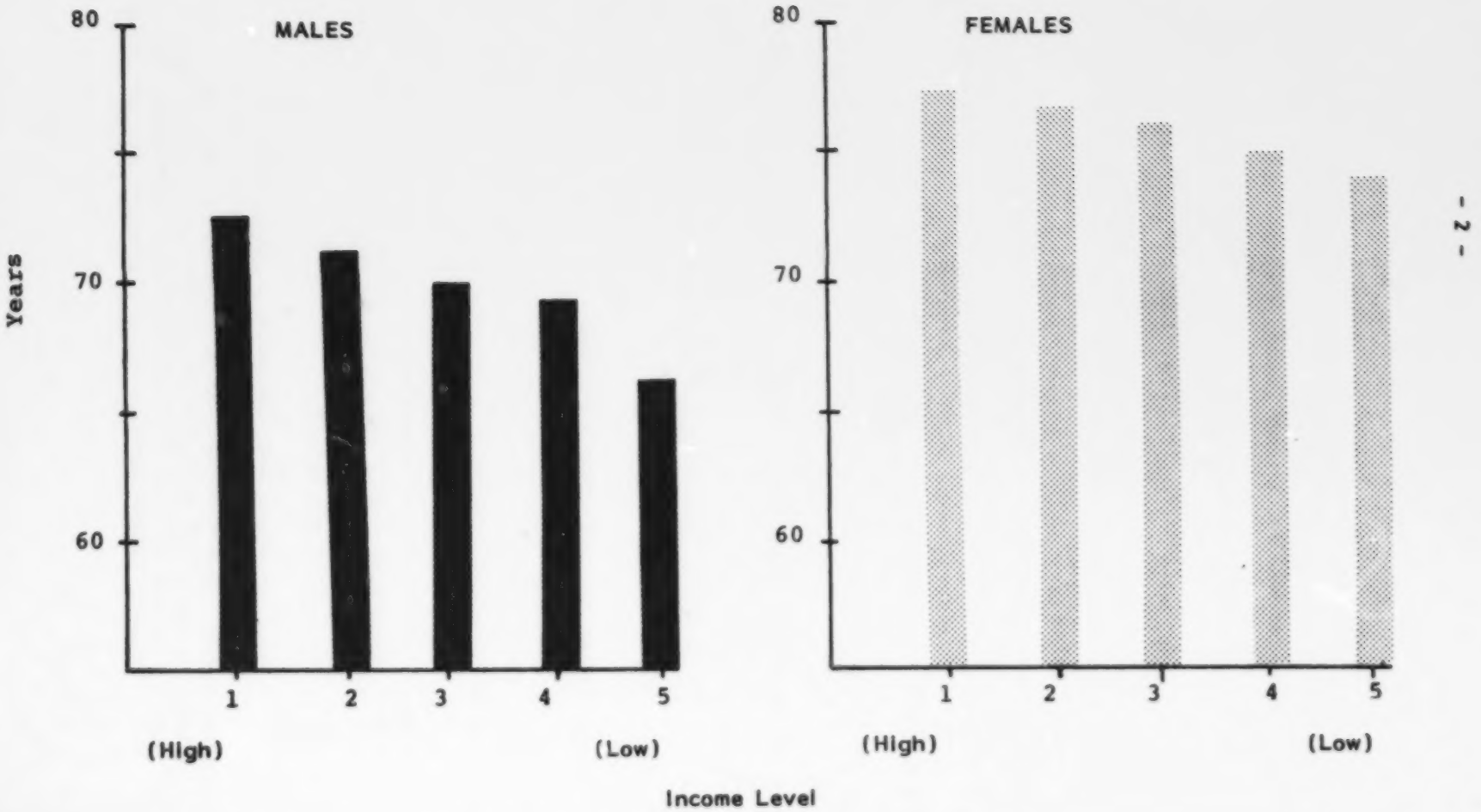
Poverty must be measured not just in terms of dollars and cents. It also takes its toll in health. Low-income Canadians face higher than average risks of premature death, illness and disability.

The Health Protection Branch of National Health and Welfare compared the life expectancy of Canadians from different income levels. The results show a clear link between income and life-span.

In 1971, the average life expectancy at birth for low-income males was 66.3 years. Male babies born into the highest-income group, in contrast, could expect to live on average 72.5 years -- more than six years longer than their low-income counterparts. Women showed similar though less pronounced differences; those in poor families had an average life-span of 74.6 years, compared to 77.5 years for newborn females in the top income category.

TABLE 2

LIFE EXPECTANCY AT BIRTH BY SEX AND INCOME LEVEL, 1971



The relationship between income and life expectancy is direct and consistent. The lowest-income group has the lowest life expectancy; the second-lowest income group, the second-lowest life expectancy; and so on up to those in the highest income group who live longest. Table 2 on the preceding page depicts the income/life expectancy pattern.

Infant mortality rates are also tied to income. Babies born to low-income parents are almost twice as likely to die before their first birthday as infants in the highest-income families. The lower the income level, the higher the infant mortality rate. The following table summarizes the results.

TABLE 3

INFANT MORTALITY RATES BY SEX AND INCOME LEVEL, 1971

Deaths per 1,000

Income Quintile	Male	Female
Lowest	24.1	18.4
Second	20.0	14.3
Middle	17.9	12.4
Fourth	15.0	11.4
Highest	12.3	9.9

Infants raised in low-income families face greater than average odds of dying as a result of complications during pregnancy and labour, crib deaths and congenital problems involving the circulatory and respiratory systems. Poor children from ages one to 14 encounter higher than normal risks of death due to cancer, respiratory disease and congenital anomalies. For those between 15 and 34, life on a low-income increases the chances of dying from heart disease, suicide and homicide. Poor people in the 35 to 64 year-old group are more susceptible to death from tuberculosis, cancer, diabetes, pneumonia and respiratory disease.

The Health and Welfare report is not the only Canadian research to show that poor people tend to live shorter lives. A Montreal study found that residents of low-income neighbourhoods could expect to live on average 68 years -- five years less than the city-wide average and nine years behind the life expectancy for affluent areas. The researchers' conclusions are startling:

> While the residents of Montreal's most favoured areas enjoy a life expectancy unsurpassed by any country in the world, life expectancies in the least favoured areas are more typical of third world countries, or about the same as those enjoyed by the average Canadian some 30 years ago.

Poor Canadians also face a higher risk of illness than those in the middle and upper-income categories. Until recently, there was only limited and impressionistic evidence to support this argument. However, the 1980 Canada Health Survey provides nation-wide information on the health status of different groups within the population.

The survey found a marked link between income and illness. The low-income group accounted for 25% of all health problems even though it represented only 20% of the population. The non-poor majority, in contrast, reported only 75% of all health problems, yet made up 80% of those surveyed. In simple terms, poor Canadians have more than their share of health problems.

Those in the lowest-income group had a disproportionate share of illnesses such as heart disease, bronchitis and emphysema, diabetes and anemia. They also were more likely to show symptoms of anxiety and depression than higher-income respondents. In all, poor people faced an above-average risk in 18 out of 21 health problems recorded by the Canada Health Survey. Appendix A summarizes the results.

Medicare and the Health Gap

The health risks confronting low-income Canadians are rooted in the conditions of life below the poverty line. Inadequate nutrition, overcrowded and substandard housing, unsafe working and living conditions, irregular employment and unstable income take their toll on the health of poor adults and children alike. Poverty creates stress which, in turn, increases susceptibility to physical and psychological illness and weakens the body's capacity to fight infection and recover from sickness.

Medicare and the health services it provides cannot possibly cut the link between poverty and illness on their own. A realistic solution to the health gap also requires social policies -- income security, social services and employment programs in particular -- that attack poverty itself and lessen its effects.

Nonetheless, an accessible health system remains the first line of defence against the physical and psychological damage inflicted on families which live in poverty. Low-income Canadians, more than anyone else, need the best that modern medicine has to offer. While medical and hospital services mainly respond to illness, health programs directed at the early detection of disease and the prevention of health problems thorugh better nutrition, prenatal care and lifestyle can help reduce the health risks facing poor adults and children.

As the architects of medicare understood full well, health care must be accessible to everyone. Only a program of national health insurance could overcome the major barrier -- lack of money -- that traditionally kept low-income Canadians away from the health system.

The evidence clearly shows that medicare rapidly improved access to health care for poor and modest-income patients. Before medicare, low-income citizens faced the highest health risks yet used the health system least. Once medicare made health care available on the basis of medical need rather than ability to pay, poor Canadians substantially increased their consumption of health services.

Researchers at McGill University found that poor Montreal families increased their visits to the doctor by 18% during the first year that Quebec's medical insurance plan came into effect. Those in the second-lowest income group had a 9% rise; middle-income households showed no change, while those in the upper-income category actually saw their doctors somewhat less. Studies done in Alberta and Saskatchewan concur that low-income Canadians benefited most from the introduction of medicare.

The Quebec experience dispels the myth that national health insurance led to abuse of the health system. In fact, medicare helped those who really needed medical attention, most of all low-income patients with legitimate health problems.

The Montreal survey asked its respondents if they had experienced any of 14 common symptons -- ranging from persistent cough and chest pain for adults to bronchitis among children -- which warrant a doctor's diagnosis. Before medicare, the health gap showed up in two ways. Low-income men, women and children reported the highest incidence of all but one of the symptoms. They also were least likely to have consulted a doctor about their health problem.

Medicare had two beneficial effects. Although the average frequency of all Montrealers' visits to the doctor did not change appreciably, the rate of consultation for persons reporting potentially serious symptoms of illness increased substantially after the medicare plan's first year of operation. And while poor people still experienced a disproportionate share of the symptoms, public medical insurance enabled them to enjoy the largest gain of all the income groups in obtaining a doctor's diagnosis.

The coming of medicare to Quebec also brought dramatic improvements in access to preventive health care. The proportion of women visiting a doctor before their third month of pregnancy rose from 41% to 55% after only one year of public medical insurance. The rate of prenatal consultation among low-income women more than doubled from 27% to 56%. There was a similar increase in the number of women bringing their infants for medical examinations; again, poor mothers benefited most.

Just three years after the last province joined medicare, the traditional upside-down pattern of health consumption -- where poor people used the health system least -- had been reversed.

APPENDIX A

SHARE OF HEALTH PROBLEMS, POOR AND NON-POOR CANADIANS, 1979

	POOR		NON-POOR	
	Share	Index	Share	Index
All Health Problems	24.9%	1.25	75.1%	0.94
Specific Health Problems				
Mental Disorder	34.7	1.74	65.3	0.82
Heart Disease	33.9	1.70	66.1	0.83
Bronchitis/Emphysema	31.9	1.60	68.1	0.85
Sight Disorder	31.4	1.57	68.6	0.86
Arthritis/Rheumatism	28.3	1.42	71.7	0.90
Diabetes	28.3	1.42	71.7	0.90
Hypertension	28.3	1.42	71.7	0.90
Influenza	27.8	1.39	72.2	0.90
Hearing Disorder	27.4	1.37	72.6	0.91
Asthma	26.9	1.35	73.1	0.91
Digestive Disorder	26.7	1.33	73.3	0.92
Anemia	26.3	1.32	73.7	0.92
Gastric/duodenal Ulcers	26.0	1.30	74.0	0.93
Dental Problems	25.3	1.26	74.7	0.93
Thyroid	24.5	1.23	75.5	0.94
Limb/Joint Disorders	23.2	1.16	76.8	0.96
Acute Respiratory	22.3	1.12	77.7	0.97
Headache	21.8	1.09	78.2	0.98
Skin	17.7	0.89	82.3	1.03
Trauma	15.9	0.79	84.1	1.05
Hay Fever	15.2	0.76	84.8	1.06

Note

Figures under "share" show the percentage of each health problem reported by the poor and non-poor. The "index" divides each income group's share of a health problem by its share of the population. The higher the index, the more disproportionately the group experiences a health problem. For example, poor people accounted for 24.9% of all health problems but only 20.0% of the population, giving an index of 1.25. The comparable index for the non-poor (0.94) shows they bear less than their share of health problems.

APPENDIX C

FINANCING HEALTH AND HIGHER EDUCATION IN CANADA:
Manitoba Examines the Issues

1986/87 Budget
Province of Manitoba

FINANCING HEALTH AND HIGHER EDUCATION IN CANADA: Manitoba Examines the Issues

TABLE OF CONTENTS

A National Commitment to Health Care and Higher Education 1

Rising Requirements 1

The Impact of Technology 4

Expenditure Requirements and Resource Constraints 4

Sources of Revenue -- 1977/78 through 1984/85 — A Declining Federal Share 4

Sources of Revenue -- 1985/86 through 1990/91 — Federal Cutbacks Place Services at Risk 7

Will Services Survive in Poorer Provinces 9

The Position of the Government of Manitoba 12

Other Provincial Statements 12

Summary 13

Conclusion 14

Table: Financing Health and Higher Education Programs, Canada, 1977/78 to 1990/91

FINANCING HEALTH AND HIGHER EDUCATION IN CANADA: Manitoba Examines the Issues

A NATIONAL COMMITMENT TO HEALTH CARE AND HIGHER EDUCATION

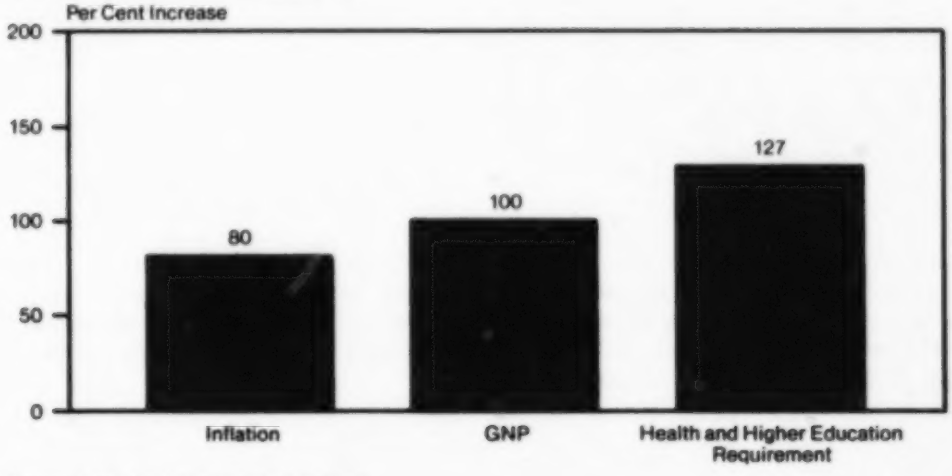
Canada has developed a unique and effective delivery system for health and higher education programs. A partnership has been formed between two levels of government. Reflecting both the major commitment of the federal government and the constitutional jurisdiction of the provinces, this partnership has aimed at lessening regional disparities, correcting the constitutional balance between federal and provincial responsibilities, and providing revenue from both levels of government.

Our health and higher education services evolved only as a result of a strong commitment by provincial and federal governments. Universally accessible and of high quality, they are now cornerstones of the security and opportunity available to all Canadians. They are recognized by ordinary Canadians as cherished rights, to be preserved, protected and enhanced by the governments which created them.

RISING REQUIREMENTS

During the period 1977/78 through 1984/85, health and higher education requirements grew at an average annual rate of 5.8% above inflation and 3.5% above the rate of growth in the economy as measured by Gross National Product (GNP).

Health and Higher Education Requirement, 1977/78 to 1984/85



Source: Manitoba Department of Finance
Statistics Canada

In future, the resources required for these services will reflect driving factors of demographics and technology. The ageing of the population and the cost of applying advanced technology will increase health costs at a rate of 2% above nominal economic growth for the next decade, according to the Conference Board.

Growth in Canadian Population Over Age 65

Year	65+ Population ('000)	Average Annual Growth Rate %	Percentage Growth Over Period %	Share of Population %
1981	2,361	3.1	–	9.7
1990	3,086	3.0	30.7	11.6
2000	3,831	2.2	24.1	13.5
2010	4,449	1.5	16.1	15.1
2020	5,733	2.6	28.9	19.1
2030	7,064	2.1	23.2	23.7

Sources: Statistics Canada, Historical Statistical Compendium, prepared for the Royal Commission on the Economic Union and Development Prospects for Canada (Ottawa: Statistics Canada, 1985), Table 1.7, and Population Projections for Canada and Territories 1984 to 2006 (Ottawa: Minister of Supply and Services Canada, Forthcoming), Projections Series Number 1.

Medium Fertilty, Low Immigration Scenario – Table 7-32.

Contrary to many expectations, enrolment in post-secondary education has not diminished or even peaked. Both full- and part-time students attend in record numbers, and quotas are increasingly being used to cope with enrolment pressure.

Post-Secondary Enrolment, Canada

	University		Community College
	Full-Time	Part-Time	Full-Time
1982/83	426,389	266,380	295,586
1983/84	450,531	278,700	313,364
1984/85	460,810	276,390	317,020

Note: Table does not include Senior Matriculation Enrolment which is included in EPF definitions of post-secondary education.

Sources: Statistics Canada, Education in Canada, Cat. 81-229 for 1982/83 and 1983/84 and Advance Statistics of Education, Cat. 81-220 for 1984/85.

Canada's public health programs now provide high-quality services more efficiently than the mixed public/private care system which exists in the United States. The share of our Gross National Product which we devote to health care expenditure is about 20% less, and our programs cover all of our citizens equally. Over 35 million Americans, lacking health insurance, are restricted in the health care they can access.

If, over concern for immediate financial costs, sick people do not seek medical advice, effects of their illness can be magnified and take an even heavier toll on them, on their families and on society as a whole. Illness reduces productivity. Illness not treated at an early stage can complicate treatment later.

Under Medicare, the economic security of Canadian families is not greatly threatened by illness. For many Americans, illness and high treatment costs can often mean financial hardship for the entire family.

THE IMPACT OF TECHNOLOGY

New technology is making its presence felt not only in health care. In the workplace and at home, people around the world are taking advantage of the technological revolution. Increasingly, technology expands our ability to treat illness. Whether for diagnosis or for treatment, health care professionals rely on expensive and advanced technological equipment.

Canadians must have up-to-date opportunities for training and for retraining if they are to be equipped to compete in the new age of technology. Neither demands on post-secondary institutions for appropriate and costly education and training, nor the demand for technological hardware itself, are likely to diminish. Manitoba believes education and training are a sound investment in our youth and others.

EXPENDITURE REQUIREMENTS AND RESOURCE CONSTRAINTS

Needs and demands for health and higher education services are clearly felt. Yet, it is also clear that we are constrained in responding. The total economic pie, or Gross National Product, suffered from the severe recession of the early 1980s, and in spite of reasonable growth in the last few years, is not likely to show long-term growth in line with the previous post-war period. The recession has left its marks, including increased deficits and painfully-slow progress in reducing unemployment. Deficits dampen the ability of governments to respond to current needs. Governments are under pressure to reduce their "take" from the national economy, while at the same time, the demands for services in health and education suggest that these programs require an increased share of our national effort.

Most forecasters, including, for example, the Conference Board, the Canadian Medical Association and the federal government's Task Force on Program Review, project that the requirement for service expansion in health and higher education will continue. In turn, this will be translated into an increasing proportion of our Gross National Product being devoted to these services. In line with these forecasts, the growth rate of programs is projected at GNP plus 2% annually. Given current federal government projections for inflation and the economy, this means that over $56 billion will be devoted to these services in 1990/91, versus $37 billion in 1985/86, and $15 billion in 1977/78.

SOURCES OF REVENUE — 1977/78 THROUGH 1984/85 — A DECLINING FEDERAL SHARE

Under the Established Programs Financing Arrangements, the federal Departments of Health and Welfare and of the Secretary of State make cash payments to the provinces out of federal budgetary appropriations. As shown in the graph on page 6 (with detail appended on pages 16 and 17) these totalled $3.8 billion in 1977/78 and covered just over

one-quarter (26%) of health and higher education requirements. By 1984/85, these cash payments had risen to $8.2 billion, but this increase failed to keep pace with program and service requirements, and provided only 24% of total financing.

Under earlier federal-provincial arrangements and extended by the EPF arrangements of 1977/78, the federal government has ceased to levy, and the provincial governments have added to their taxes, 13.5 personal tax points and one corporate income tax point.[1] These **"tax transfers"** from the federal government, now raised by provincial governments, are included for equalization in similar fashion to the equalization of other provincial revenues.

The value of the tax points, including the associated equalization, was $3.3 billion in 1977/78, and $6.4 billion in 1984/85. The share of health and higher education financed by these tax points dropped from 22% in 1977/78, to 19% in 1984/85.

The federal government adds the value of the equalized tax points to federal cash transfers to derive a total for federal EPF funding. Under that scenario, the total federal transfer rose from 48% of program requirements in 1977/78, to 50% in 1979/80, and then dropped to 43% in 1984/85.

However, the taxes "transferred" in 1977/78 are in fact levied by provinces and now are identified in the public's mind as provincial taxes. In Manitoba, the provincial income tax rate of 54% of basic federal tax includes the tax transfer. The budgetary figure for the federal government is simply the "cash" payment.

Hence, provincial taxpayers financed the majority of health and post-secondary education spending. In addition to the tax points contributed as noted above, the primary source of this funding is **general revenues** of the provinces supplemented by **local government contributions** and institutional own-source revenues **such as tuition fees. The total of this additional funding provided 52% of programs financing in 1977/78, dropped to 50% in 1979/80, and then rose to 57% in 1984/85. The dollar value was $7.8 billion in 1977/78, and $19.3 billion in 1984/85.**

The total from provincial taxpayers **was $25.6 billion or 76%, versus 24% from the federal Budget in 1984/85.**

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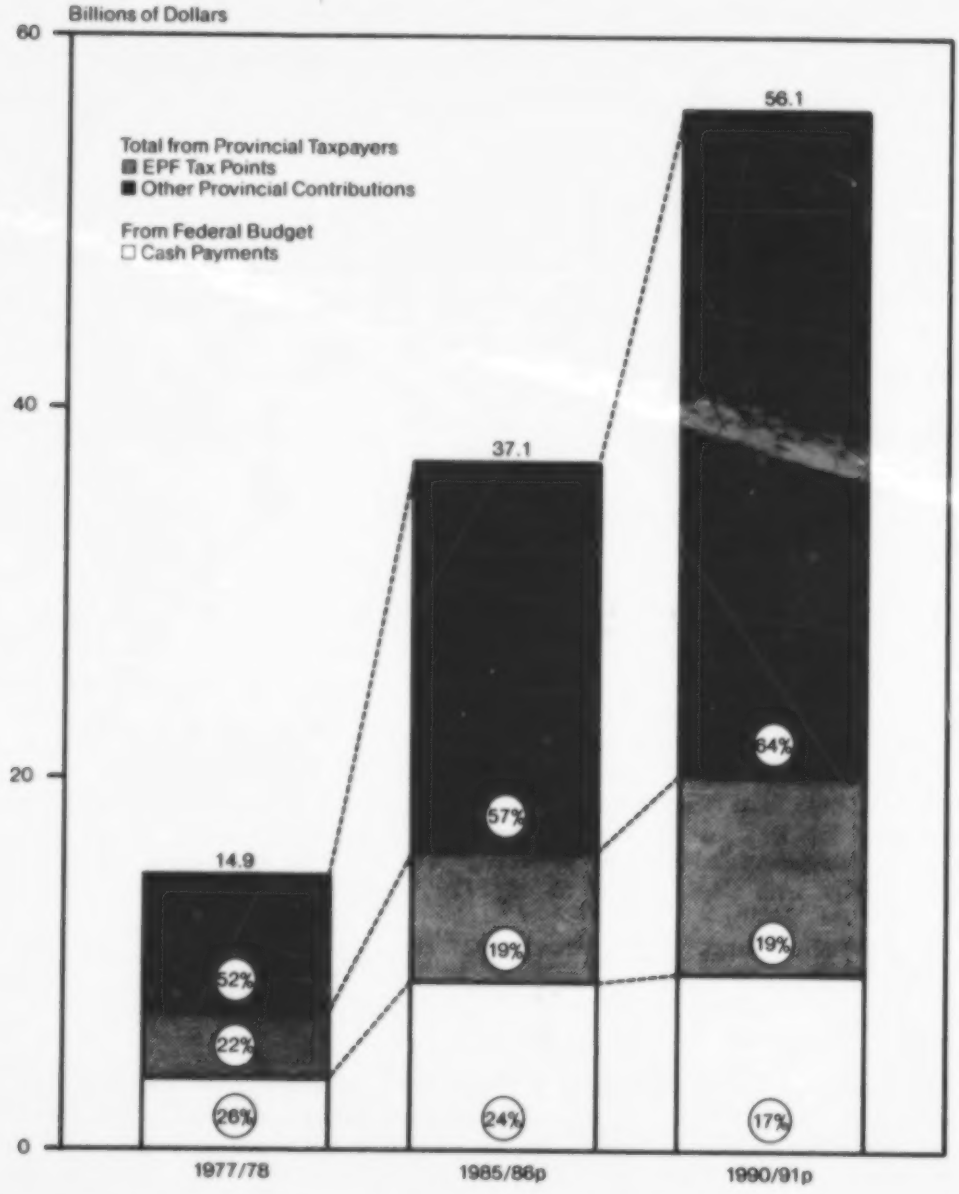
[1] The total transfer covers 13.5 percentage points of personal income tax and one percentage point of corporation income tax. However, 4.357 percentage points of personal income tax and the one point of corporate income tax had been transferred earlier (in 1967) as part of the former post-secondary financing arrangements. Consequently, the net new transfer involved only 9.143 points of personal income tax.

Financing Health and Higher Education, Canada, 1977/78 to 1990/91
By Source



p – projected

Source: Federal Department of Finance
Manitoba Department of Finance
The Conference Board in Canada

SOURCES OF REVENUE PROJECTED — 1985/86 THROUGH 1990/91 — FEDERAL CUTBACKS PLACE SERVICES AT RISK

The most recent projections provided to provinces with the February, 1986 Budget incorporate **the federal government plans to slash $2 billion from federal health and higher education transfers annually by 1990/91. Bill C-96 to effect the cuts is now before Parliament.**

The forecasts show federal cash transfers growing very slowly over the next five years -- from $8.8 billion in 1985/86, to only $9.8 billion in 1990/91. The growth rate is 2% annually, slower than the rate of inflation, and very much slower than the rate of growth of the economy. In comparison with the projected $19 billion increase in costs of maintaining services, the $1 billion increase provides less than 5%. The **share** of financing provided by the federal budget plunges **from 24% in 1985/86, to 17% in 1990/91.**

The value of 13.5 personal income tax points, and one corporate income tax point (equalized) is projected to rise from $7.0 billion in 1985/86 to $10.9 billion in 1990/91, a percentage increase roughly in keeping with costs.

In the face of the miniscule rise in federal cash payments, it is not surprising that the federal government wishes to focus only on presentations which incorporate the tax points (one-quarter of provincial personal income tax revenue) as a federal contribution. However, even with this addition, federal arithmetic would show contributions at a rate 2% below the rate of growth in the economy, while costs are projected to increase by 2% above the rate of GNP growth. The drop in the **federal share** under this formulation mirrors the plunge in the proportion provided by the cash transfers, dropping **from 43% in 1985/86 to the 36%-37% range in 1990/91.**

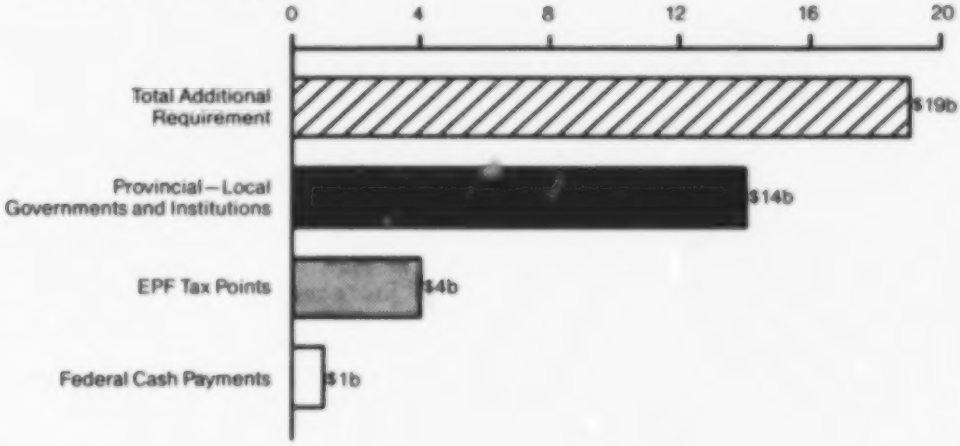
If the health and post-secondary education needs of Canadians are to be met with full access to programs of the quality we enjoy today, provincial taxpayers will be called upon to provide $18 billion more in 1990/91 ($46 billion versus $28 billion in 1985/86).

Of the $19 billion additional funding required by 1990/91, only $1 billion will be forthcoming from the federal Treasury.

Adding the increase in the tax points to the $1 billion increase in the cash transfer provides a total of $4.9 billion or about one-quarter of the projected increase in total requirements.

Increased Health and Higher Education Requirements, 1985/86 to 1990/91

Sources of Funding



Source: Federal Department of Finance
Manitoba Department of Finance

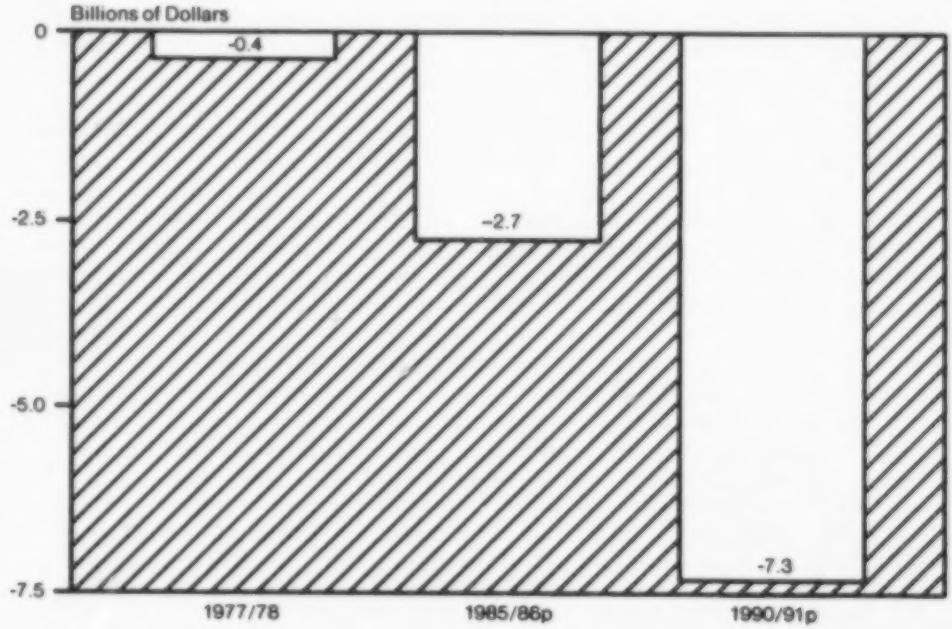
There is serious concern that provinces, especially the poorer provinces, will not be able to meet these funding requirements. Thus, unless the deleterious effects of Bill C-96 are reversed, both service quality and universality are at risk.

WILL SERVICES SURVIVE IN POORER PROVINCES?

Provinces currently devote about 28% of their total provincial program expenditures ($27 billion) to health care, with a further 7% ($7 billion) devoted to higher education. Thus, over 35% of provincial program expenditures are for health and higher education.

Since the beginning of the decade, provinces have shouldered not only their own share of the increasing cost, but an additional $2.8 billion which represents the shortfall of federal funding from a 50% share. As noted earlier, federal transfers under Bill C-96 will not keep pace with projected expenditure requirements. By 1990/91, the shortfall in federal funding will increase to $7.3 billion.

Shortfall from 50-50 Funding
Federal Cash Payments plus EPF Tax Points



p—projected

Source: Federal Department of Finance
Manitoba Department of Finance

For Manitoba, that shortfall translates into about $300 million annually. That amount in program terms means:

- the entire expenditure on universities and community colleges;
- the budget of all hospitals in Manitoba except for St. Boniface and the Health Sciences Centre; or
- more than the total combined salaries of all doctors or all nursing homes and Pharmacare costs in Manitoba.

For other provinces, the shortfall is of a similar magnitude. What will provinces do in such circumstances?

The Government of Newfoundland and Labrador recently issued "A Green Paper on Our Health Care System Expenditures and Funding." In it they outlined the options available to them:

- privatization, in whole or in part, of the health care system;
- changes (cutbacks) in health care expenditures beyond those already implemented;
- deficit financing; and
- tax changes.

The federal government Task Force on Expenditure Review is more definitive in its view of what will transpire if the federal funding cuts proceed. In addition to noting that "there are no compelling program reasons to reduce transfer payments," the Review Team noted in its Report:

> "Cost escalation is a concern for all provinces and there is no evidence that any jurisdiction will be able to hold cost increases at or below the inflation rates in the forseeable future. Provinces feel that the impacts of aging, technology, medical manpower and usage rates are and will continue to exert substantial upward pressures on costs. In this situation, **an EPF escalator based on GNP is likely to result in federal payments growing at a rate slower than health costs.**
>
> "Reductions in federal funding under EPF will, for the provinces, result in one or more of the following:
>
> - transfer of health costs to individuals (within the limits of the Canada Health Act);
> - increased taxes at provincial levels;

- reduction in services and/or quality of health care services;

- reduction in provincial programs in areas other than health care."[2]

The impact of the federal cutbacks will be felt first and most severely in the equalization-recipient provinces. The Equalization Program already leaves the recipient provinces with a fiscal capacity which is $217 per capita below the all-province average. Therefore, service provision is already under severe cost-containment pressure in these provinces -- before taking account of the added fiscal responsibilities they are being asked to bear by the federal government.

The alternative means of coping with their share of the acknowledged increased resource requirements are all less palatable in the poorer provinces.

For example, a basket of across-the-board tax increases in the equalization-recipient provinces would generate from 60% (in Newfoundland) to 80% (in Manitoba) of what they would raise nationally. Public debt is higher and credit ratings are lower in the equalization-recipient provinces, making further increases in deficit financing less attractive. As noted, the full range of provincial services are under greater cost- containment pressures, and, therefore, reductions in other services in order to finance health and higher education increases are less feasible.

Therefore, reductions in service quantity and quality and transfer of costs to individuals through fees or privatization loom larger. **These are threats to the basic tenets of our public systems of health care and of higher education.**

---

[2] Health and Sport Volume -- Study Team Report to the Task Force on Program Review, page 90.

THE POSITION OF THE GOVERNMENT OF MANITOBA

In a series of statements, papers and submissions, the Government has stated:

1. That the quality and accessibility of public health and higher education programs must be preserved.

2. It would damage principles of universal access, and it would be more costly, if Canadians had to turn to private delivery for some services. The Government of Manitoba wants Medicare for all, not private care for the privileged few. Public institutions must fill most of the need for higher education and training.

3. To maintain the quality and accessibility of services in the face of increasing needs, the federal government must reassert itself as a full partner, and federal funding must increase in response to needs and demands.

The Government of Manitoba has received broad and enthusiastic support for these positions from organizations and individual citizens in Manitoba. The Manitoba Coalition on Health and Higher Education, composed of health organizations, university administration, faculty and students, labour groups and others, representing in all 34 organizations and over 250,000 Manitobans, has been formed to fight for fair federal funding to protect these important services.

OTHER PROVINCIAL STATEMENTS

Other provincial governments are also speaking out:

> "The Government of New Brunswick has objected in the strongest terms to the long standing federal strategy of leaving provinces with more and more of the responsibility for funding health and education programs. Federal participation in the financing is essential because most provinces do not have the resources to pay for these programs themselves." (New Brunswick Budget, 1986, p. 6)

The 1986 Quebec Budget details not only the cuts which result from passage of Bill C-96, but also the cuts which have been made in federal financing for health and higher education since 1982. In doing so, it quotes the current federal Minister of Finance who said in 1982:

> "The only sign it (the federal government) shows of cutting spending is by shifting the burden of the established programs funding onto the provincial governments. The provinces are now moving into a

> deficit position, a position which will make it more difficult for them to finance this shift in spending .... That is not cooperative federalism. That is predatory federalism and it will not and cannot work in this country." (Michael Wilson, House of Commons Debates, March 23, 1982)

With regard to the consequences of the reduction in federal transfers, the Quebec Budget states:

> "Government spending is increasingly being squeezed in a vice. Health costs are growing rapidly because the population is aging and because of the introduction of new medical technologies, while the federal government is avoiding its financial responsibilities in this sector." (Quebec Budget, 1986/87, p. 12-13)

Premiers, Health Ministers and Eduction Ministers of all provinces have produced joint statements opposing the cuts.

SUMMARY

Federal forecasts show that the federal cash transfers for the five-year period 1986/87 through 1990/91 will total $47 billion compared with $37 billion in the previous five years. The value of the tax points will be $46 billion over the next five years compared with $31 billion in the previous period. (See Table appended).

Though these numbers permit the federal government to assert EPF cash and tax will total $93 billion, **up $25 billion** from the last five years, such comparisons are deceitful. The increases are largely reflections of the high rates of inflation during the early 1980s. In addition, the costs of providing more people with health and higher education are estimated at $240 billion over the next five years, **up $83 billion** from the $157 billion total in the previous five years. **Requirements of $83 billion matched against federal cash of $10 billion and tax points of $15 billion show the true picture.**

Thus, the damaging implications of the federal position become clear. As stated earlier, the federal government, after the cutbacks proposed in Bill C-96, would provide only an additional $1 billion on an annual basis in 1990/91. Health and post-secondary education spending is projected to rise by $19 billion by then.

And, federal revenue is projected by them to rise by $35 billion.

CONCLUSION

We believe the federal government can and should provide a fair share of resources for these services. For example, Ottawa has found:

- more than $1 billion for bank bail outs;
- more than $2 billion in capital gains and other tax breaks favouring the wealthy;
- more than $1.6 billion in corporation income tax rate reductions;
- another $3.3 billion to increase defence spending by 35% to $12.6 billion by 1990/91.

The federal government either places an extremely low priority on health and higher education services, or it believes it can transfer a major portion of its projected deficit onto provincial governments. That is, of course, in complete contradiction to stated federal intentions, but is the pragmatic result if they proceed with cuts while provinces maintain services.

The Manitoba Government will work with the concerned citizens of this province in presenting an effective case against federal cutbacks to Canadians and to Parliamentarians throughout our nation. The security and opportunity afforded Canadians through their public health and higher education programs must not be slowly strangled by cutbacks in federal support. These hard-won rights of the Canadian people must be respected. We will continue our efforts until the fiscal threat to these programs is removed, fair federal funding secured, and the future of health and higher education is no longer at risk.

Financing Health and Higher Education Programs
Canada, 1977/78 to 1990/91
By Source of Revenue

($ Millions)

		1977/78	1981/82	1982/83	1983/84	1984/85	1985/86	FIVE-YEAR TOTAL 1981/82 TO 1985/86
1	Total Provincial-Local Government Health and Institutional Post-Secondary Education Requirements	**14,943**	**25,139**	**29,026**	**31,744**	**33,855**	**37,100**	**156,864**
	FEDERAL BUDGET							
2	Cash Transfer	**3,818**	**6,113**	**6,449**	**7,549**	**8,209**	**8,802**	**37,122**
3	(% share)	**26**	**24**	**22**	**24**	**24**	**24**	**24**
	PROVINCIAL TAXPAYERS							
4	Value of Tax Points[a]	3,297	5,664	5,950	6,021	6,380	6,962	30,977
5	(% share)	22	23	21	19	19	19	20
6	Other Contributions[b]	7,828	13,362	16,627	18,174	19,266	21,336	88,765
7	(% share)	52	53	57	57	57	57	56
8	**Total Provincial**	**11,125**	**19,026**	**22,577**	**24,195**	**25,646**	**28,298**	**119,742**
9	**(% share)**	**74**	**76**	**78**	**76**	**76**	**76**	**76**

		1985/86	1986/87	1987/88	1988/89	1989/90	1990/91	FIVE-YEAR TOTAL 1986/87 TO 1990/91
	Total Provincial-Local Government Health and Institutional							
1	**Post-Secondary Education Requirements[c]**	**37,100**	**40,300**	**43,800**	**47,600**	**51,700**	**56,100**	**239,500**
	FEDERAL BUDGET							
2	Cash Transfer[d]	**8,802**	**9,045**	**9,219**	**9,381**	**9,533**	**9,757**	**46,935**
3	(% share)	**24**	**22**	**21**	**20**	**18**	**17**	**20**
	PROVINCIAL TAXPAYERS							
4	Value of Tax Points[a]	6,962	7,684	8,481	9,299	10,143	10,928	46,535
5	(% share)	19	19	19	20	20	19	19
6	Other Contributions[b]	21,336	23,571	26,100	28,920	32,024	35,415	146,030
7	(% share)	57	58	60	61	62	63	61
8	**Total Provincial**	**28,298**	**31,255**	**34,581**	**38,219**	**42,167**	**46,343**	**192,565**
9	**(% share)**	**76**	**78**	**79**	**80**	**82**	**83**	**80**

a Tax points transferred to provinces in 1977/78 are included in provincial tax rates payable by provincial taxpayers. The figures include equalization payable on those provincial taxes.
b Primarily Provincial General Revenues and including Local Government and Institutional Own-Source Revenues.
c Assumes GNP growth of 7.6% in 1985/86 and an average of 6.6% thereafter and expenditure growth of GNP plus 2%. (Based on Conference Board report suggesting health costs in United States will rise from 10% of GNP in 1980 to 12% in 1990; i.e., growth in economy plus 2% annually.)
d Federal Department of Finance, February 25, 1986 – after cuts – GNP minus 2% proposal.

Sources: Federal Department of Finance,
Manitoba Department of Finance (1986/87 to 1990/91 Projected),
Interprovincial Committee on EPF Data.

APPENDIX D

SOCIAL EXPENDITURE IN OECD COUNTRIES

1960-1981

Table 3

Social Expenditure in OECD Countries: 1960-1981

	Social Expenditure as a Percentage of GDP		Real Social Expenditure per capita: US$		Annual Growth Rate of Real GDP		Annual Growth Rate of Real Social Exp.	
	1960	1981a	1960	1981a	1960-75	1975-81a	1960-75	1975-81a
USA	10.9	21.0	422	1,196	3.4	3.2	7.7	2.9
Japan	8.0	17.5	81	639	8.6	5.1	9.7	8.9
Germany	20.5	31.5	380	1,876	3.8	3.0	6.7	1.9
Canada	12.1	21.7	369	1,028	5.1	3.3	9.5	2.9
France[b]	13.4	23.8	272	936	5.0	2.8	7.4	7.6
Italy	16.5	29.1	204	344	4.6	3.2	7.4	3.1
United Kingdom	13.9	24.9	290	547	2.6	1.0	5.6	3.3
Australia	10.2	18.6	231	627	5.2	2.4	8.6	2.4
Austria	17.9	27.9	246	1,180	4.5	2.9	6.0	4.6
Belgium	17.0	38.0	298	2,176	4.5	3.0	9.1	4.6
Denmark	10.2	29.0	260	1,107	3.7	2.2	9.3	4.4
Finland	13.2	-	272	n.a.	4.5	2.9	7.3	-
Greece	8.7	12.8	53	145	6.8	3.5	7.8	2.3
Ireland	11.7	27.1	132	275	4.3	3.5	8.2	5.2
Norway	11.7	27.1	249	1,470	4.3	4.1	9.5	5.6
Netherlands	16.3	36.1	304	1,514	4.5	2.0	9.2	1.4
New Zealand	13.0	19.6	342	386	4.0	0.4	4.4	3.7
Sweden	14.5	33.5	425	1,650	4.0	1.0	8.4	4.0
Switzerland	7.7	14.9	197	1,292	3.4	1.8	6.9	2.5

Notes: a. Or latest year available; b. Excluding education expenditure.

Sources: SME/SAIR/SE/83.02
The Growth of Social Expenditure: Overview and Main Issues; OECD Paris, France, August 18, 1983.